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The use of Enhanced Recovery after Surgery (ERAS) to decrease length of stay and increase patient satisfaction: An integrative Research Review

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Impact of Enhanced Recovery after Surgery or (ERAS) on Length of Stay and Patient Satisfaction: An integrative Research Review

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Background & Significance

- In a day and age where reimbursement for medical practices is tied to patient satisfaction, it is essential to emphasize patient satisfaction when looking at outcomes in relation to interventions.
- Data on hospital-based surveys link patient care, patient satisfaction, and reimbursement (Price et al. 2014)
- The most commonly used survey is the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS), also known as H-Caps. The data derived from this metric determines reimbursement based on the patient experience.
- The premise underlying the survey is the notion quality outcomes and high levels of patient satisfaction lead to quality improvements and better reimbursement (Price et al. 2014)

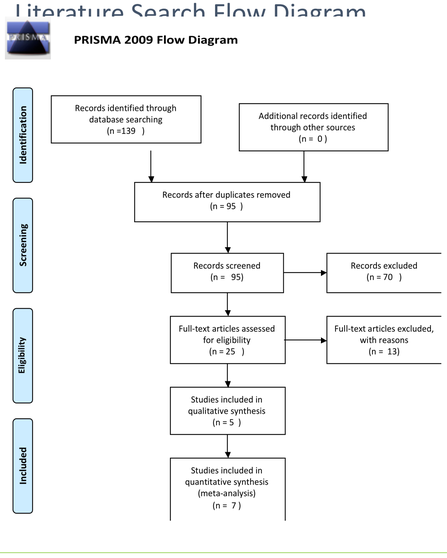
Research Question

In the postoperative patient will adherence of Enhanced Recovery after surgery or ERAS practices decrease length of stay (LOS) and improve patient satisfaction?

Methodology

- Search strategy included seven databases- Cochran Library, CINAHL, Medline, PubMed, Nursing Academic, DynaMed plus, and Health Source using Whittemore's methodology (2005)
- Keywords "ERAS or enhanced recovery after surgery," patient satisfaction," and "length of stay"
- Inclusion Criteria "peer-reviewed," "academic journal" between the years of 2014-2019.
- Exclusion Criteria "non academic articles" years later than 2014.

Literature Search Flow Diagram



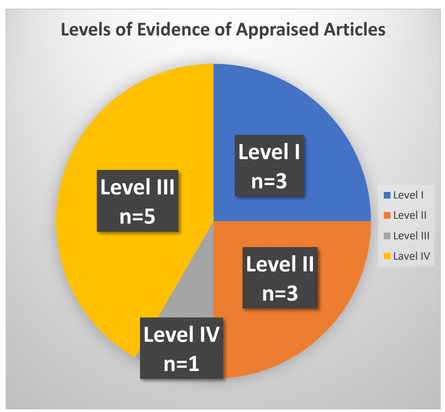
https://www.google.com/search?q=pictures+of+surgery+patient+recovering&source=lnms&tbm=isch&sa=X&ved=0ahUKEwjlnojAulzhAhVGL6wKHf-4BfYQ_AUIDigB&biw=1127&bih=685#imgrc=5vNqnzbI1o1tKM:

Interpretation

- Programs differ between studies because standard pathways were not uniform (Miralpeix et al., 2016, Keller et al., 2016)
- Evidence suggests adherence to ERAS will decrease LOS; improve patient satisfaction, while improving patient outcome (Pearsall et al., 2015, Miralpeix et al., Springer et al., 2019, Alawadi et al., 2016, Kalogera et al., 2018, Frees et al., 2017, Zang et al., 2018, Keller et al., 2016, Martin et al., 2018, Thiele et al., 2015, Jones et al., 2014)
- Differences include type of anesthetic protocol used during surgery- opioid-sparing total intravenous anesthesia versus intraoperative opioid consumption and use of carb loading prior to surgery (Miralpeix et al., 2016, Pearsall et al., 2015, Alawadi et al., 2016, Kalogera et al., 2018, Frees et al., 2017, Zang et al., 2018, Keller et al., 2016, Thiele et al., 2015)
- Purpose of ERAS is to optimize nutritional and functional status of patients (Springer et al., 2019, Kalogera et al., 2018) and to promote autonomy to improve return to baseline function (Miralpeix et al., 2016, Zang et al., 2018, Keller et al., 2016)

Results

- 139 articles identified with 44 duplicates resulting in 95 total articles being critically appraised-using evaluative checklists and the EBR tool
- 83 articles were excluded due to irrelevance, reducing the total number to 12 manuscripts for review.



Literature Synthesis

- ERAS programs focus on reducing perioperative stress, achieving pain control, resumption of normal gastrointestinal function, and early mobilization (Miralpeix et al., 2016, Springer et al., 2019, Kalogera et al., 2018, Keller et al., 2016, Cui et al., 2016, Thiele et al., 2015)
- ERAS pathways are multimodal, multidisciplinary care pathways to promote earlier recovery after surgical procedures by maintaining baseline organ function, while reducing the stress response and maintaining homeostasis (Pearsall et al., 2015, Miralpeix et al., 2016, Springer et al., 2019, Frees et al., 2017, Zang et al., 2018, Keller et al., 2016,Kalogera et al., 2018)
- Consistent findings were limitation of preoperative fasting, patient-specific analgesia (including epidurals to avoid excessive narcotic use), least invasive surgery approaches, and early postoperative ambulation and feeding. (Miralpeix et al., 2016, Springer et al., 2019, Kalogera et al., 2018, Zang et al., 2018, Keller et al., 2016, Cui et al., 2016, Thiele et al., 2015)

Discussion

- Implementation of this multimodal, multidisciplinary pathway is posing difficult due to lack of standardization (Kalogera et al., 2018, Keller et al., 2016, Martin et al., 2018, Thiele et al., 2015); requiring clear communication across multiple disciplines (Miralpeix et al., 2016, Springer et al., 2019, Cui et al., 2016, Martin et al., 2018, Thiele et al., 2015) and with lack of Nursing support (Springer et al., 2019, Keller et al., 2016, Martin et al., 2018)
- Identified barriers to ERAS utilization are adequate staffing and lack of nursing time. (Pearsall et al., 2015, Alawadi et al., 2016, Martin et al., 2018) Both barriers present challenges to nursing practice.
- ERAS represents best clinical practice and has been adopted across many surgical specialties; however, further efforts are needed to standardize pathways to encourage widespread implementation to decrease length of stay and improve patient satisfaction (Kalogera et al., 2018, Zang et al., 2018, Keller et al., 2016, Thiele et al., 2015)

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